



## Appendix M Forms

### 2005 Mobilization Plan

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The following forms are found in this section. They are available by contacting your Regional Coordinator or the Emergency Mobilization Section (360) 753-0498 or (360) 753-0565.

<b>Form Name:</b>	<b>Used For / By:</b>
Mobilization Request	Fire Chief to request Mobilization
Regional Resource Availability	Regional Coordinators
Agency Reimbursement Invoice	Agencies seeking reimbursement for personnel
Individual Time Record	Agencies – attaches to Agency Reimbursement Invoice
Expense Claim Invoice	Anyone submitting a claim for expenses
Injury / Exposure Report	Anyone who is injured or exposed to a hazard
Loss/Damaged Equipment	Used to record loss or damage to equipment
Mobilization Manifest	Anyone Responding to a Mobilization
Sample Delegation of Authority	Local Fire Chief
Sample Agency Administrator In-Brief	Local Fire Chief
Model Agreement – For Temporary Employees	Local IAFF and Agency
Sample Resolution for Compensation	Agency
WSP Waiver	Anyone being reimbursed by Mobilization
IRSS / ITS Check In-Form	Anyone responding to a Mobilization
After Action Review	Anyone participating in a Mobilization
Mobilization Common Question Guideline	Anyone participating in a Mobilization



# Request For Mobilization Form

## 2005 Mobilization Plan

WSP/EMD Use Only

Date/Time Received:

Date/Time Approved:

Mobilization # : WA – WFS – \_\_\_\_\_

### Mobilization Authorization

Date of Request:

Time of Request:

Requesting Agency:

Phone: (     )

Fire Chief or Designee:

Phone: (     )

On Scene I/C:

Phone: (     )

Regional Fire Coordinator:

Phone: (     )

Has the Regional Coordinator been contacted? [Yes] [No] Who:

### Incident Location

Type of Incident:

Size (acres, blocks, miles)?

Weather:

Location of Incident: (Describe location relative to roads/towns):

County:

Nearest City:

Is the incident in your fire jurisdiction? [Yes] [No] Is it imminently threatening your jurisdiction? [Yes] [No]

Have local resource been exhausted? [Yes] [No] Has mutual aid been expended? [Yes] [No]

Does the event jeopardize the ability of the local jurisdiction to protect lives and property? [Yes] [No]

What is at risk? (number of lives/homes/crops)

Evacuations? [Yes] [No] [Probable]

Estimated number of people to evacuate?

What land is it on? (Check all that apply) ☐ Private ☐ Federal ☐ State ☐ Unprotected

### Resources Needed

What specific resources are needed?

### Reporting Area

Command Post: Location (address)

Contact Person:

Phone: (     ) \_\_\_\_\_

FAX this document to the State Emergency Management Division's State Emergency Operations Officer at (253) 512-7203.

**Call 1-800-258-5990 for the State Emergency Operations Officer.**



## 2005 Mobilization Plan

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# Regional Resource Availability Form

## 2005 Mobilization Plan

Region:			Coordinator:			Phone:		
<b>Type 2 Team Positions</b>				<b>Type 3 Team Positions</b>				
Position	Certified	Trainee		Position	Certified	Trainee		
I/C				I/C				
IIO				IIO				
SOF				SOF				
OPS				OPS				
LSC				LSC				
FSC				FSC				
DIVS				DIVS				
RESL				RESL				
EQTR				EQTR				
PTRC				PTRC				
COML				COML				
SPUL				SPUL				
GSUL				GSUL				
TIME				TIME				
PROC				PROC				
COST				COST				
<b>Other Overhead Positions</b>								
STL / TFL				Trainee				
SRB				Trainee				
Technical				Trainee				
<b>Equipment</b>								
Can Commit Resources Either As Single Resources or Strike Team/Task Force But Not Both								
Single Resource				Strike Team		or	Task Force	
Type 1							<b>Urban Task Force</b>	
Type 2							3 STE, 1 Aerial, 1 CV	
Type 3								
Type 4							<b>Rural Task Force</b>	
Type 5							3 STE, 2 WT, 1 CV	
Type 6								
IF Attack							<b>Interface Task Force</b>	
Type 1 WT							2 STE, 2 WLE, 1 WT, 1 CV	
Type 2 WT								
Type 3 WT							<b>Wildland Task Force</b>	
BLS Unit							3 WLE, 1 WT, 1 CV	
ALS Unit								
Command								



## 2005 Mobilization Plan

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# Agency Reimbursement Invoice Form

## 2005 Mobilization Plan

<b>Agency Name:</b>		<b>Event Name:</b>	
<b>Address:</b>		<b>Federal Tax ID #:</b>	
<b>City:</b>		<b>Phone #:</b>	
<b>State:</b> Washington	<b>ZIP:</b>	<b>Contact Name:</b>	

**Reimbursement for the Following Agency Personnel:**

Name	Regular Hours	Overtime Hours	Regular Rate	Overtime Rate	Sub-Total
1			\$	\$	\$
2			\$	\$	\$
3			\$	\$	\$
4			\$	\$	\$
5			\$	\$	\$
6			\$	\$	\$
<b>Agency Personnel Sub-Total</b>				\$	-

**Reimbursement for Backfill of Agency Personnel:**

Name	Overtime Hours	Overtime Rate	Sub-Total	1/3 of Sub-total
1		\$	\$	\$
2		\$	\$	\$
3		\$	\$	\$
4		\$	\$	\$
5		\$	\$	\$
6		\$	\$	\$
7		\$	\$	\$
8		\$	\$	\$
<b>Agency Backfill Sub-Total</b>			\$	

**Totals**

Agency Personnel Sub-Total	\$
Agency Backfill Sub-Total	\$
Total Agency Reimbursement	\$

Completed by:	Phone #:
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**Return Within 45 Days of the Mobilization To:**  
 Emergency Mobilization Section  
 PO Box 42600  
 Olympia WA 98504

**Questions Call:**  
 360-753-0498 or  
 360-753-0565  
 360-570-3136 (Fax)

## Agency Reimbursement Invoice For Personnel Instructions

### Form Use:

This form is for jurisdictions to claim for career employee's reimbursement.

### Completing Form:

- Using the Reimbursement Worksheet, fill in the boxes with information requested.
- Use N/A for those not applicable.
- Attach one Reimbursement Worksheet for each employee listed.
- Use one form per resource number assigned to an event.
- If you need additional space, attach additional forms.

### Reimbursement For The Following Agency Personnel:

Name		Regular Hours	Overtime Hours	Regular Rate	Overtime Rate	Sub-Total
1	Doe, John	24	14	\$ 10.00	\$ 15.00	\$ 240.00
2	Smith, Walter	0	38	\$ 10.00	\$ 15.00	\$ 510.00
3				\$	\$	\$
Agency Personnel Sub-Total						\$ 750.00

### Reimbursement for Backfill of Agency Personnel

Name		Overtime Hours	Overtime Rate	Sub-Total	1/3 of Sub-Total
1	Parker, Robert	24	\$ 15.00	\$ 360.00	\$ 120.00
2			\$	\$	\$
Agency Backfill Sub-Total					\$ 120.00

### Totals

Agency Personnel Sub-Total	\$ 750.00
Agency Backfill Sub-Total	\$ 120.00
Total Agency Reimbursement	\$ 870.00

Return The Completed Form Within 45 Days Of The Event.

Emergency Mobilization Section  
PO BOX 42600  
OLYMPIA WA 98504



# Individual Time Record Form

## 2005 Mobilization Plan

Event Name:		Resource Order Number:	
Employees Name:			
Seeking Reimbursement for: (Check One Only)		Mobilized Staff	Backfill

### Total Cost of Compensation:

Eligible Cost	Regular Rate	Overtime Rate
Base Hourly Rate: (No benefits or premiums included)	\$	\$
Social Security (Hourly): ____% (If applicable)	\$	\$
Medicare (Hourly): ____%	\$	\$
LEOFF / PERS (Hourly): ____%	\$	\$
L&I Insurance (Actual Hourly Rate) Overtime is same as regular time	\$	\$
Shift Premium	\$	\$
Medical / Dental Insurance	\$	Not applicable
Total Cost of Compensation Rate	\$	\$

### Hours Worked:

Date	Start Time	End Time	Scheduled Hours Worked	Overtime Hours	Assigned Shift (A, B, C, D) Day Off
Total Hours Worked					

### Reimbursement Sought:

	Rate	Total
Scheduled Hours	\$	\$
Overtime Hours	\$	\$
Backfill Hours	\$	\$
<b>Total</b>		\$

Backfill Total is Hours x Rate, divided by 3.

**\*\*ATTACH ONE FORM PER PERSON PER EVENT TO THE AGENCY REIMBURSEMENT FOR PERSONNEL FORM\*\***

**Return Within 45 Days of the Mobilization To:**  
Emergency Mobilization Section  
PO Box 42600  
Olympia WA 98504

Questions Call:  
360-753-0498 or  
360-753-0565  
Fax: 360-570-3136



## Mobilization Form Instructions

### Individual Time Record Form

#### Form Use:

This form is to be used to show how the Total Cost of Compensation was derived and providing a record of the hours which you are seeking reimbursement for.

#### Completing Form:

- Fill in the boxes with information requested.
- Use one form per employee, per event. If employee went to event and also filled a backfill/replacement role, two forms are needed, one for each assignment.

### EXAMPLE

Eligible Cost	Regular Rate	Overtime Rate
Base Hourly Rate (No benefits or premiums included)	\$ 10.00	\$ 15.00
Social Security (Hourly): ____% (If applicable)	\$ 1.50	\$ 3.00
Medicare (Hourly): ____%	\$ 1.00	\$ 2.00
LEOFF / PERS (Hourly): ____%	\$ 3.00	\$ 4.50
L&I Insurance (Actual Hourly Rate) Overtime is same as regular time	\$ .37	\$ .37
Shift Premium (if applicable)	\$	\$
Medical / Dental Insurance	\$ 4.50	Not applicable
Total Cost of Compensation Rate	\$ 21.37	\$ 24.87

#### Hours Worked:

Date	Start Time	End Time	Scheduled Hours Worked	Overtime Hours	Assigned Shift (A, B, C, D)
7/1/05	16:00	23:00	0	5	Day Off
7/2/05	06:00	07:00	0	1	Day Off
7/2-3/05	07:00	07:00	24	0	A
7/3/05	07:00	18:00	0	11	Day Off
7/4/05	06:00	11:30	0	5.5	Day Off
Total Hours Worked			24	22.5	

#### Reimbursement Sought:

	Rate	Total
Scheduled Hours <b>24</b>	\$ 21.37	\$ 512.88
Overtime Hours <b>22.5</b>	\$ 24.87	\$ 559.56
Backfill Hours	\$	\$
Total		\$ 1,072.44

Backfill Total is Hours x Rate, divided by 3.

This is an example of a career fire jurisdiction employee who is called in to respond to a mobilization request. On 7-2 the employee starts their scheduled 24 hour shift.

Return The Completed Form Within 45 Days Of The Event.

EMERGENCY MOBILIZATION SECTION  
PO Box 42600  
OLYMPIA WA 98504



## Expense Claim Invoice Form

### 2005 Mobilization Plan

**Agency / Person to be Reimbursed:**

Name: (Agency/Person to be Reimbursed)	Event Name:
Address:	Resource Order #:
City: State: ZIP:	
Phone #:	
Federal Tax ID Number:	

**Telephone Cost:**

Attach Copy of phone bill.				
Phone bill from	Date	to	Date	\$
Phone bill from	Date	to	Date	\$
Sub-Total				\$

**Meals:**

Attach receipts. Actual meal cost up to the state per diem limits are reimbursed.			
Date	Names of those meals purchased for:	Restaurant Name	Sub-Total
			\$
			\$
			\$
			\$
Sub-Total			\$

**Lodging:**

Attach receipts. Actual lodging costs up to state per diem limits are reimbursed.			
Date	Names of those lodging purchased for:	Hotel / Motel Name	Sub-Total
			\$
			\$
			\$
			\$
Sub-Total			\$

**Other: Loss or Damaged Equipment**

Attach receipts showing replacement costs. For Damaged Equipment – attach a Damaged Equipment Report			
Date	Loss or Damaged Equipment (Be specific)	Vendor Name	Sub-Total
			\$
			\$
			\$
			\$
Sub-Total			\$

**Total**

\$

**Claimant:****Date:**

I certify that the foregoing is true and accurate under the laws of the state of Washington that the information provided here is true and accurate.

**Return Within 45 Days of the Mobilization To:**  
Emergency Mobilization Section  
PO Box 42600  
Olympia, WA 98504

Questions Call:  
360-753-0498 or  
360-753-0565  
Fax: 360-570-3136

**EMERGENCY MOBILIZATION SECTION  
PO BOX 42600  
OLYMPIA WA 98504**



# Injury / Exposure Report Form

## 2005 Mobilization Plan

### COMPLETE AT TIME OF INJURY / EXPOSURE BY INDIVIDUAL OR SUPERVISOR

Name:	Date of Birth	- -
Address:	Home Phone:	( )
City:	Work Phone:	( )
State: ZIP:	Message Phone:	( )
Fire Agency Affiliation:	Agency Number:	( )

Date of Injury/Exposure:	Time: (am) (pm)
Location of Injury/Exposure:	County:
Extent of Injury/Exposure:	
Describe How Injury/Exposure Occurred:	

Did You Receive Medical Treatment at Time of Injury?	YES	NO	Location:
Did You Receive Additional Medical Treatment?	YES	NO	Facility:
Has a Labor & Industries Claim Been Filed By You?	YES	NO	Claim #:
Was a Third Party Involved in Your Injury/Exposure?	YES	NO	Identify below
Third Party Name:		Phone: ( )	
Address:			
City:		State:	ZIP:
Witness:		Phone: ( )	

Reviewer	Printed Name	Signature	Date
Immediate Supervisor			
Division Supervisor:			
Medical Unit Leader:			
Safety Officer:			
Incident Commander:			

**Fax Within 24 Hours of Injury / Exposure To:**  
Emergency Mobilization Section  
PO Box 42600  
Olympia WA 98504

Questions Call:  
360-753-0498 or  
360-753-0565  
Fax: 360-570-3136

**Mobilization Form  
Instructions**

**Personal Injury/Exposure Report**

**Form Use:**

This form is to be used for notification of personal injury / exposure at an event.  
It does not replace an Labor and Industries Claim form.

**Completing Form:**

Either the employee or supervisor will complete this form and fax it to the Washington State Patrol within 24 hours of the incident.

- Fill in the boxes with information requested.
- Use N/A for those not applicable.
- Be detailed as to the mechanics of the injury or exposure.
- A third party injury would be where someone else is directly responsible for the injury/exposure.

**Review Section:**

The only two required boxes to be completed are the Immediate Supervisor and Safety Officer.

The Safety Officer will attach any forms completed regarding this injury/exposure and fax to the Washington State Patrol, Emergency Mobilization Section.

Attach copies of any reports or investigations completed regarding the injury or exposure.

Fax to the Washington State Patrol – Emergency Mobilization Section  
within 24 hours of the Incident.

**Send Originals to:**

EMERGENCY MOBILIZATION SECTION  
PO BOX 42600  
OLYMPIA WA 98504  
Fax (360) 570-3136



# **Loss / Damaged Equipment Form**

## **2005 Mobilization Plan**

Agency or Person	
Name: (Agency or Person to be Reimbursed)	Event Name:
Address:	Resource Order #:
City:	State: ZIP:
Phone #:	
Federal Tax ID Number: (Social Security Number for a Person – Needed if seeking reimbursement.)	

Type of Incident (circle one)					
Vehicle Damage/Incident		Equipment Damage		Loss of Equipment	
Date of Incident:			Time of Incident: (am) (pm)		
Location:					
Description of Property Loss/Damaged					
Year		Make			
Model		Color		Style	
Size/Length		Serial Number			
Mileage	(For Vehicles)	License Plate	(For Vehicles)	State	(For Vehicles)
Estimated Value		Replacement Cost			
Other					
Insured	(Yes) (No) Check One	Insurer:			
Claim Filed	(Yes) (No) Check One	Claim Number:			

Attach a statement describing in detail what happened	
Witness:	Phone:
Witness:	Phone:

Investigation - Attach copy of Investigation or use space provided on back of this notice.	
Investigated by:	Phone:
Date Damage Loss Reported:	Time:
Damage/loss caused or contributed by the dynamics of the incident: (Circle One) (Yes) (No) (Undetermined)	

***** No Investigation – No Reimbursement for Damages *****			
Claim Reviewed By:	Print Name	Signature	Date Reported
Immediate Supervisor			
Division Supervisor			
Safety Officer			

**Return Within 45 Days of the Mobilization To:**  
 Emergency Mobilization Section  
 PO Box 42600  
 Olympia WA 98504

Questions Call:  
 360-753-0498 or  
 360-753-0565  
 Fax: 360-570-3136

## Loss/Damaged Equipment Notice

This form is to be used to report at an event, equipment that is lost or damaged.

## Report Incidents Immediately

## Completing Form:

- Fill in the boxes with information requested.
- Use N/A for those not applicable.
- Complete the form on behalf of an individual or Agency.
- Use one form per resource number assigned to an event.
- Describe the lost or damaged item in detail.
- Attach a statement describing in detail what happened and be sure to sign and date it.
- Most importantly – have the loss/damage investigated.

## **If There Is No Investigation - There Will Be No Claim Reimbursed**

## Review Section:

This section requires at minimum, the Immediate Supervisor's and or the Division Group Supervisor's signatures.

A copy of this form needs to be left at the incident.

# Investigation Report

[illegible]

# Mobilization Manifest Form



<b>Incident Name:</b>
<b>Resource Order Number:</b>

## 2005 Mobilization Plan

<input type="checkbox"/> <b>Initial Response Crew</b>		<input type="checkbox"/> <b>Crew Change-Out (Requires I/C Approval)</b>		<input type="checkbox"/> <b>Initial Attack</b>	
<b>Time Requested:</b>		<b>Estimated Time of Departure:</b>		<b>Estimated Time of Arrival:</b>	
<b>Fire Jurisdiction:</b>		<b>Federal Tax ID #:</b> Required		<b>Date:</b>	
<b>Equipment #</b>		<b>Vehicle License #</b>		<b>Equipment Type Sent</b>	
<b>Name</b>		<b>Equipment Type Requested</b>		<b>AWD:</b> Yes / No	
<b>Name</b>		<b>Equipment Type Requested</b>		<b>CAFS:</b> Yes / No	
<b>Name</b>		<b>Equipment Type Requested</b>		<b>Estimated Hourly Rate</b>	
<b>Name</b>		<b>Equipment Type Requested</b>		<b>Estimated Hourly Rate</b>	
<b>Name</b>		<b>Equipment Type Requested</b>		<b>Estimated Hourly Rate</b>	
<b>Name</b>		<b>Equipment Type Requested</b>		<b>Estimated Hourly Rate</b>	
<b>Name</b>		<b>Equipment Type Requested</b>		<b>Estimated Hourly Rate</b>	

**\*\* If you are being paid by your home agency – check “Paid by Home Agency; if you are going to be paid by the Washington State Patrol – check Paid by WSP.**

**Positions:**  
 STL/TFL – Strike Team / Task Force Leader  
 ENGB – Engine Boss (must be carded)  
 STPS – Structure Protection Specialist  
 I/C – Local Incident Commander  
 DRVR – Driver, vehicle requires a CDL license + EVAP  
 SOF – Safety Officer  
 FF – Firefighter 1 or 2 both structural or wildland  
 DIVS – Division Group Supervisor  
 \*\*\* - T – Used to designate trainee position by adding a T

**Engine Typing:**  
 Type 1 – 1,000 GPM Pump + 400 Gallon Tank;  
 Type 4 – 70 GPM + 750 Gallon Tank;  
 Type 7 – 20 GPM Pump + 125 Gallon Tank;  
 Type 2 – 500 GPM Pump + 400 Gallon Tank;  
 Type 5 – 50 GPM Pump + 500 Gallon Tank;  
 Interface Attack – 250 GPM Pump + 500 Gallon Tank (carries air packs, ladder and tools found commonly on a Type 1 or 2 engine.  
 Type 3 – 120 GPM Pump + 300 Gallon Tank;  
 Type 6 – 20 GPM Pump + 125 Gallon Tank;

**Tender Typing:**  
 Type 1 – 300 Gallon Pump + 5000 Gallon Tank;  
 Type 2 – 200 GPM Pump + 2500 Gallon Tank;  
 Type 3 – 200 GPM Pump + 1000 Gallon Tank

**FAX COPY TO STATE EOC PRIOR TO LEAVING**

**253-512-7234**

Manifest Needed for Check-in

Top Copy: To Finance Section

And Payment Process

Bottom Copy: Strike Team Leader



Mobilization Manifest  
Form  
Instructions

Form Use:

This form is to be used to record personnel and equipment being sent to an incident either as a single resource or as a strike team/task force.

Completing Form:

Use one form per resource number assigned per event. Complete the form and fax to the State Emergency Operations Center prior to leaving for the event. The State Emergency Operations Center will forward the information to the event. This will allow the incident to start putting resources into an operational plan.

When checking into the event, provide the Finance Unit the original copy, the other copy will go the Strike Team/Task Force Leader.

Crew Change-Out: The replacement crew will need to only complete the Resource # and Event Name and the bottom half of the manifest. Only complete the top half of the manifest if there is a change. Fax a copy to the State Emergency Operations Center prior to leaving for the crew change out. It is the home jurisdiction's responsibility to obtain the Incident Commanders approval for a crew change prior to the change-out.

- Fill in the boxes with information requested.
- Use N/A for those not applicable.
- The hourly rate for a volunteer is from the Interagency Rate Agreement.
- The hourly rate for a career employee is the regular hourly rate. This is needed for the Incident Cost Accounting Reports (ICARS).
- Inform the time unit of duty status e.g., if on overtime status and local labor agreements, e.g., pay for all hours away from duty-station or pay for hours worked only.

☒Initial Response Crew

☐Crew Change-Out (Requires I/C Approval)

☐Initial Attack

Time Requested: 18:30		Estimated Time of Departure: 20:30		Estimated Time of Arrival: 01:00		Date: 8/7/04	
Fire Jurisdiction: Pierce County # 6				Federal Tax ID #: 91-1234567		Cell Phone Number: (253) 555-1212	
Equipment # E-23	Vehicle License # 12345D	Equipment Type Requested Wildland Engine	Equipment Type Sent Type 6	AWD: Yes / No CAFS: Yes / No		Pump Rate in GPM: 50 Tank Size in Gallons: 200	
Name Robert Smythe		Agency if different than above	POB 78, Tacoma WA 98343	X Paid by Home Agency <input type="checkbox"/> Paid by WSP		Estimated Hourly Rate \$ 23.50	
Name Allen Jones		Agency if different than above	12344 168 <sup>th</sup> Ave E, Tacoma 98445	X Paid by Home Agency <input type="checkbox"/> Paid by WSP		Estimated Hourly Rate \$ 41.50	
Name Barbara White		Pierce # 23	POB 45334, Graham WA 98447	X Paid by Home Agency <input checked="" type="checkbox"/> Paid by WSP		Estimated Hourly Rate \$ 11.50	
						Position FF	
						Position ENGB	
						Position FF	

FAX to the State Emergency Operations Center

Prior to Leaving for Event.

253-512-7234